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Parental Grief: Traumatic Death of a Child and Length of Bereavement
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Abstract

There is much empirically based research and case studies in the area of grief itself but few that focus on traumatic grief. For the purpose of this study, we will focus on traumatic grief as it applies to the death of a child. Traumatic grief is defined as a grave form of bereavement that comes about when the death of a loved one is caused by an accident, an impaired driver, SIDS, homicide, suicide, or an act of terrorism. There is no time to say goodbye. The research that has been done indicates that with these types of death, the time it takes to grieve is prolonged over a greater period. The biographies written by five parents (N=5) whose child had died in a traumatic incident were used in this study. The evidence gathered from the readings indicates that with a traumatic death, the grieving period is greater in length. Real world application for this type of study would be to provide valuable information to those who counsel grief stricken parents. Their needs are unique to the type of death of their child and the methods to offer support to them need to be tailored to their specific set of circumstances. It is warranted and necessary.

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For a parent, the death of a child is a devastating event. In a world where all that happens is fair, a parent does not outlive his/her child. This was so when my son, Jeffrey died. The therapist I saw after his death told me that there were no words in the English language that could adequately express my grief. She was right. The grief that accompanies such an event is beyond the scope of description of any spoken language. This paper will address the topic of whether the type of death as defined by a traumatic death prolongs the length of time a parent will grieve for his/her child. Research indicates, when the parent is not able to say goodbye due to the circumstances of the death of the child, the grief is compounded.

In attempting to study this topic, we will also incorporate the five stages of grief as established by the work of Dr. Elisabeth Kubler-Ross (1969). The original focus of her work was to explore how terminally ill patients dealt with their own death and dying (Kubler-Ross, 1969). Her initial work has become far more encompassing than intended and can be applied to persons who are grieving the loss of a loved one. The five stages are: (1) denial; (2) anger; (3) bargaining; (4) depression; and, (5) acceptance. Originally the progression through the stages was suggested to take a linear path but it seems that Dr. Kubler-Ross's work was misunderstood. She states, "These means (the five stages of grief) will last for different periods of time and will replace each other or exist at times side by side (Kubler-Ross, 1969, p. 147). This suggests the stages represent a list to refer to, in no particular order, with some persons moving from one stage to the next and then returning to a previous stage or skipping a stage all together. Grief is personal and as different in its expression as there are snowflakes in a snowstorm, unique and individual. "Each individual within a family will have particular grief for the unique relationship with the lost family member" (Anderson, 2010, p. 130).

There is a very personal aspect of this topic for me. My son Jeffrey died ten years ago in a work related accident. I received a phone call from my sister at 6:00 pm in the evening on Friday, January 6th, 2006 that Jeff had been in an accident and was in the hospital. After talking with her, I called the hospital to check on his status and was given very little information. I was told that he had severe head trauma and that we needed to come as soon as possible. Jeffrey lived in Redding, California with his girlfriend and his daughter, Alyssa. We arrived at the hospital at around 11:00 pm and proceeded to the ICU. The registered nurse who was assigned to care for Jeff came out and explained the extent of Jeffrey's injuries. My knees buckled at hearing the list. We were then buzzed into the ICU and escorted to Jeff's room. The team of doctors who worked on Jeff in the emergency room came a bit later to discuss Jeff's prognosis and the news was not good. He was on life support with a respirator and there was no hope for his recovery. We made the decision to donate his organs and corneas for transplant and he was declared legally dead on Saturday, January 7th. This is the date on his death certificate but to me, he died on January 6, 2006.

After he was declared legally dead, the preparations began to set up the surgery to harvest his organs and his corneas for transplant. We were allowed to be in the ICU with him until the transplant team took Jeff into the operating room on Monday. Friends and family came to the hospital over the course of the weekend to sit with Jeff one last time. When I was in his room alone I cried so many tears. I talked to him and held his hand. It was the most difficult four days of my life. The grief that I felt at the death of my 25-year-old son was all encompassing. The hurt was in every cell and organ of my body or at least it felt that way to me. The sorrow was with me every minute of every day and affected all aspects of my life. Work, caring for my home, my husband and my 18-year-old daughter felt like a mountain too tall to climb. I had no

appetite and I had difficulty sleeping all night. I wanted to talk to him one more time and say goodbye. I wanted him to be here to raise his two-year-old daughter. My prayers were not heard and I began the slow and painful process of trying to find a new normal in a world that no longer included my son. For me personally, I did not feel much of any kind of relief from the sadness until Jeff had been dead for about eight and one half years.

Grief is defined as “the normal but bewildering cluster of ordinary human emotions arising in response to significant loss, intensified and complicated by the relationship to the person or the object lost, and by the way the person dies” (Anderson, 2010, p. 128). Grief includes an emotional, cognitive and somatic component of a person’s reaction to a death (Jacobs, Mazure & Prigerson, 2000). It is multifaceted and incorporates the enormity (degree of awfulness of death), the relationship of the grieving person to the person who died, and the justice (age and cause of death) into defining the depth grieving to take place (Regehr & Sussman, 2004). Complex or traumatic grief as it is titled today is associated, for the most part, with what we perceive as a violent death. It involves a purposeful act by a human or some type of negligence (Anderson, 2010). The types of death that fall under this heading of traumatic grief are suicide, homicide, death caused by an impaired driver, an act of terrorism, and SIDS. Though the level of grief can be related to any person, our focus will be the grief a parent feels at the death of their child. In order to explore this idea of parental grief and traumatic death of a child, we must first understand the definition of the concepts.

A dissertation that was later published as a journal article studied the predictors of grief following the death of a child (Keese, 2001; Currier, Keese & Neimeyer, 2008). These predictors were that the type or violence of the death, the age of the child when they died, and the time elapsed since the death would affect the grief process. There was also an indication that

being able to make sense of or find benefit in the death influenced the degree of grief (Keese, 2001).

Participants were approached through local chapters of Compassionate Friends, using a website and a mailing list. Parents who agreed to be part of the study could fill out the two questionnaires on line or do so in hard copy. The participants were required to be at least 18 years of age. Each participant also had to be from different families and responding to the death of a different child.

In total, 157 participants were given the Core Bereavement Items (CBI) and the Inventory of Complicated Grief (ICG). Their ages ranged from 23 to 77 years of age with a mean of 49.41 years. They were from 32 states in the U.S., 2 Canadian provinces, and 4 foreign countries. There were 128 mothers and 29 fathers surveyed for this study. The majority of the parents were Caucasian (n=146), with the remainder being African American (N=6), Hispanic/Latino (N=4), and Native American (N=1) (Keese, 2001). There were 10 parents whose child died because of a miscarriage or a stillbirth. A natural, anticipated death numbered 18; a natural, sudden death numbered 31; and by an accident equaled 69. Death by homicide accounted for 10 deaths and death by suicide was 17. Time since the deaths was varied. At the time the article was published (2008), the number of years that had gone by was between 0 to 40 years with a mean length of 6 years. The age range of the children who died was 0 to 47 years with a mean of 17 years (Currier, Keese & Neimeyer, 2008).

Results indicated that the type or violence of the death of a child directly affects the grief process for the parent. It is much more difficult for these parents. Also contributing to this degree of difficulty, as the results showed, is the concept that because parents cannot make sense

of the death of their child or find any benefit to it, this too adds more time to the grief process. Age of the child at time of death had no influence (Currier, Keesee & Neimeyer, 2008) nor did the lapse in time since the death of the child and the filling out of the two questionnaires. It was also noted that the amount of time that had gone by since the death of the child did not influence the responses the parents gave on the questionnaires. In other words, time did not mute or alleviate their grief.

The modes of death or the impact that the type of death has on the bereavement process were studied through a dissertation and a longitudinal study. The parent being present at the death (Dijkstra, Schut, Stroeve, Van Den Bout & Van Der Heijden, 2006) was researched in both studies. Mode of death was split into two categories (Tombrink Dierkhising, 1992): natural and unnatural. Natural death was categorized as one in which the child died from an illness or SIDS. Unnatural death was termed as one in which the child died from homicide, suicide, or accidental death.

The participants for these two studies were asked to take part in two ways: (1) Dutch couples were contacted through obituary notices in local and national newspapers (Dijkstra et al., 2006), (2) The National Compassionate Friends group contacted a local group in Omaha, Nebraska, Compassionate Friends and asked them to talk to the parents of the monthly support group to see if they would like to participate in the study (Tombrink Dierkhising, 1992).

Dutch Parent couples numbering 219 said yes to being a part of the study. Their ages ranged from 26 to 68 years with the mean being 42.2 years. Religious affiliations were 38% Roman Catholic, 26% Protestant, 5% other religion, and 31% no religion. The children who had died had age ranges from stillborn to 29 years of age with a mean age of 10.2 years. Male

children who had died made up 68.7%. The cause of their deaths were: neonatal death which included stillborn was at 16.3%, illness made up 47.7%, and accident, SIDS, suicide, or homicide was 36.1% (Dijkstra et al., 2006, p. 241). Demographic information was gathered at six months, 13 months, and 20 months through interviews. The rate of attrition over a 14-month period was 17.8%. Each parent also filled out a questionnaire at each time period.

From the parent support group of Compassionate Friends, 28 parents took part in the study. An investigator interviewed the parents from 50 minutes to three and one-half hours. Their ages ranged from 26 to 64 years of age. The length of time since the death of their child was from four months to 13 years. The participants were made up of six males and 22 females. The ethnicity of the participants in the study was 93% Caucasian and seven percent Afro American. No other ethnicities were included. For those whose child had died a natural death, two were male and eight were female. Their ages ranged from 35 to 62 years and their children had died from four months to 13 years ago. Those in the unnatural death category were four males and 14 females with ages from 26 to 64 years. Their children had died from nine months to 12 years ago (Tombrink Dierkhising, 1992, p. 34).

In both of these studies mode of death or circumstances of the death were found to have an impact on parental bereavement. In both studies those parents whose child had died by homicide, suicide, SIDS, or accidental death reported levels and length of grieving to be higher and longer. These studies supported the concept that not being able to say goodbye to your child has a profound effect on the grief process.

The focus for this study is now going to shift to children who have died by a specific traumatic death. The three traumatic death types being used are murder, death by an impaired

driver, and accidental death. The information for these three types of death was gathered from two theses, one for a master of arts in sociology (Carter, 1997), the other for a master of education in school psychology (Kindrachuk, 1994), and one dissertation for a degree as a doctor of psychology (Quayle, 1999).

The methods used to gather information for these studies was conducted by three different means. Firstly, meticulous notes were taken during a community parental support group that the author attended with her brother after the death of her nephew, Damian who was 18 years old when he was murdered in a drive by shooting. The author did not hide her note taking and had decided if asked a direct question about what she was doing, she would answer truthfully. No parents ever inquired. Audio taping or speaking to the parents about the study was not allowed by the non-profit organization. The author attended the support group for one year and it met on a bi-monthly basis for two hours. The average number of attendees fluctuated from ten to 15 persons. No demographic information about the participants was given in the study. Social workers and family therapists facilitated the group and the facilitator rotated each quarter (Carter, 1997).

Secondly, the death of ten children by an impaired driver was studied using 13 parents in total, ten mothers, and three fathers. Of the impaired drivers, eight were drunk and three were under the influence of cocaine. The Grief Experience Inventory (GEI) was used, a standardized test instrument, and a structured interview questionnaire (Kindrachuk, 1994). The age range of the parents used in the study was from 40 to 70 years of age. The ages of the children were from ten years to 20 years with one child being a toddler. The time that had passed since the death of the child was from two to 20 years. Of the parents interviewed, ten were married, two were divorced, and one was separated.

Thirdly, ten parents, six females and four males whose child had died an accidental death took part in this study. The parents were approached in three different ways, an advertisement in a newsletter of The Compassionate Friends, through a private foundation whose purpose is to aid parents whose child has died suddenly, and by referral from a bereavement counselor at Scripps Hospital in La Jolla, California (Quayle, 1999). The ages of the children were between six years and 17 years. Automobile accidents accounted for five of the deaths, a car hit four of the children, and one child died after eating contaminated meat (Quayle, 1999). There was a range from one year to ten years since the death of the child and the interview. All the interviews took place in the home of the parent except for one, which was in the home of a family member of the parent. All individuals were interviewed separately, even the six who made three couples who were married to each other. Their ages ranged from early forties to mid fifties. Participants were from the United States (6), China (2), Argentina (1), and Germany (1). As far as education, four of the participants had post-baccalaureate degrees, two had doctorates in a branch of the sciences, two had master's degrees, four had bachelor degrees, one was a registered nurse with two years of college and one had an associated degree (Quayle, 1999). Socioeconomic status was from lower middle class to upper middle class. In the case of three parents, their only child had died while seven of the parents had other living children.

Though these studies did not directly address the topic of whether type of death has an influence on length of bereavement, it seems apparent in the stories shared by the parents in their interviews and/or the surveys they took. Even after 18 years, for one parent, whose child had been killed by a drunk driver, the grief was still being felt (Kindrachuk, 1994). As far as support offered to the parents to help them navigate their grief, three suggestions were made: (1) the passage of time; (2) professional assistance, and (3) joining a support group (Kindrachuk, 1994).

I found these three suggestions were most beneficial for me personally. I attended more than one grief group facilitated by “Hospice.” I found the group that was specific to parents whose child had died to be the most beneficial to me. There were other parents who were feeling emotions that were similar to mine. This gave me a sense of comfort and I felt less alone in my grief. I also saw a therapist for about six months after Jeffrey’s death that had aided our family in the past. She moved to San Luis Obispo after living in Santa Cruz, California for some time. I drove to meet with her once a month. For me, I wanted to talk to someone who had known Jeffrey when he was alive. The drive was worth it to me. I didn’t want to start over with someone new.

There were three emotions that were evident in all three of the articles (Carter, 1997; Kindrachuk, 1994; Quayle, 1997). These were guilt, anger, and deep and abiding sadness. Because each of these studies addressed a death of a child by traumatic means, the parent expressed a desire to have done something differently the day their child died. They felt that if they had done so, their child would still be alive. Guilt weighed heavily on them. The component of anger was intensified in the type of death, more so than in the death of a child through an accidental death or a terminal illness. In the cases in which the child dies by a homicide, or is hit by an impaired driver, the anger is at rage level and is directed at the person who is responsible for their child’s death. One of the parents said “I still absolutely hate the man and I’d be happier if her were dead” (Kindrachuk, 1994, p. 50). This sums up the feelings of the parents and the expression of their anger. The deep and abiding sadness that visits a parent after the death of their child is one in which “the mind and body shut down, seals up all openings, emotionally and physically, and puts a protective coating numbness all around” (Carter, 1997, p.

83). This is how I felt when Jeffrey died. There are no words in the English language to describe the depth of my sorrow.

Two of the studies addressed how a father of the deceased child grieves (Carter, 1997; Quayle, 1999). Mothers, by virtue of giving birth, are given a certain status while grieving their child. Fathers are left out of that circle. They are seen as the breadwinner, the one who needs to be strong, and are told, “men don’t cry.” Yet, they too, are a part of the lives of their children, caring for them, watching them grow, and loving them just as much as their wives do. A father’s grief is just as real as a mother’s grief. What differs is how men express their grief (Quayle, 1999). An example given by one father said, “Why, when the phone rings and I answer it, does the caller always ask for my wife? Why not me? He was my son too” (Carter, 1997, p. 86). It is important to acknowledge this disparity when comforting parents whose child has died. We would do well to remember that both mother and father loved their child and they are hurting equally. Please do not exclude the father just because he is a male.

In one of the three articles, the five stages of grief were addressed (Kindrachuk, 1994; Quayle, 1999). It is important to note that here, as this theory is an integral piece of this study. The five stages are denial, anger, bargaining, depression, and acceptance. As has been noted in previous paragraphs during the introduction, the stages are not linear in nature and some grieving parents move back and forth between the five during the course of their grieving journey. We will address them in order for the purpose of this discussion to avoid any confusion.

Denial was present in 70% of the participants in the Quayle study (1999). This denial manifested itself from flat out refusal to accept the death of their child, to not listening to people who told them their child had died, to being angry at people for lying to them about the death of

their child, to thoughts scurrying through their minds saying to them “this cannot be happening” (Quayle, 1994, p. 204). With a sudden or traumatic death, there is no time to prepare emotionally and denial becomes a coping mechanism, one that can get a parent through the first hours or days until the “truth” can sink in.

Anger was present in 100% of the participants. This anger had different themes. Parents expressed anger at the injustice of the world for taking their child, anger at God for allowing this to happen, anger at the doctor, hospital, and policeman for not saving their child, anger at the person who caused the death of their child, such as the impaired driver. These feelings of anger were strong when expressed by the parents. It is important to note that when a child has died by homicide or being hit by a drunk or drug high individual, the anger felt by parents is greatly increased. There is a rage and revenge component that was discussed in all the research literature read for this study. Parents blame the person who killed their child or caused the accident. There is senselessness to it and a feeling that the death could have been avoided if the perpetrator had made a different choice.

Bargaining was not expressed by any of the participants. This may be due to the fact that their children were already dead when they were notified. There was no time for any kind of bargaining.

Depression was present in 100% of the participants, including myself. The depression manifested itself in various ways. For some it was having no desire to grocery shop for special foods their child enjoyed. For others, it was having no desire to take part in Holiday celebrations. For many, the depression manifested itself in loss of appetite, inability to fall asleep or stay asleep, forgetting appointments, and/or not being able to do the usual daily tasks,

such as cooking, cleaning, or running errands. Normal everyday chores were just too overwhelming. The desire to sleep and/or cry was very strong for me. Anything I was supposed to do seemed like too much of a burden. I didn't balance my checkbook for three months and during that three months after Jeffrey died, I had no idea that I had no idea how much money was in the checking account. Looking back, all I can say is it is a good thing I keep a float in that account.

The participants in this study did not discuss acceptance, the final or fifth stage. They expressed this stage as more of a "moving on" with their lives (Kindrachuk, 1994). For the ten participants, acceptance was not a word that fit their particular journeys. One of the participants stated "It is kind of like you broke your leg and your leg is healed now but it is crooked" (Quayle, 1999, p. 207). It is not acceptance of the death but more a struggle to find a new way to be in the world without your child. For me, it was looking for a new "normal."

The study being researched here will look at parental grief as it relates to how the child died and whether the type of death has an impact on the length of the bereavement period. The question being asked for the purpose of this study is: Does the type of death, specifically a traumatic death in which the parent has no time to say goodbye lengthen the amount of years the parent will grieve for their child?

Method

Participants

The participants were five parents who had written a book about the traumatic death of their child (N=5). A purposive sampling was used as the biographies chosen were based on type of death of the child. The authors' (parents') gender was four females and one male. No demographic information was stated about the authors.

Materials and Procedure

The biographies written by the parent about the traumatic death of their child were used as materials. The topic being addressed is whether the type of death is a contributing factor to the length of bereavement by a parent. Each of the biographies told a story of a child who had died traumatically by five different methods.

As to procedure, each biography was read and information was gathered to aid in addressing the topic stated above.

Results

The five stages of grief as set out by Dr. Kubler-Ross in her book titled “On Death and Dying” will be applied to the five biographies outlined above. Though they are listed in a linear fashion, the format will not be followed for the purposes of this study. The five stages are denial, anger, bargaining, depression, and acceptance.

“Rare Bird” tells the story of Jack, a 12-year-old boy who died in a flash flood in a creek that ran through their neighborhood behind the houses. It turned into a river that spring afternoon in 2011 from heavy rains that were the tail end of a hurricane. Jack and his sister, Margaret, along with Jack’s friends, Daniel, Alexis, and Joe went out to play in the rain after getting their homework done after school. Margaret and Alexis had already headed for home before the accident. The bank gave away and Jack was swept into the creek that became a river from the rains in Joe’s backyard. Daniel and Joe did not fall in. Jack’s body was found under a bridge that was used to get to the neighborhood they lived in, trapped in a culvert with debris all around him. The biography is written from the mother, Anna Whiston-Donaldson’s perspective. Her husband, Tim, and their 10-year-old daughter, Margaret are woven into the pages also. The book was published in 2014, 3 years after the death of Jack. It describes Jack in his early years and well as

the child he was at the age of 12. It describes the type of family they were and the relationship they had with each other and with Jack, including Jack's relationship with his sister. It gives a frame-by-frame description of the day that Jack died and chronicles the funeral, and adjusting to life in a home where Jack no longer lives

The author writes of returning to work less than two weeks after Jack died and she shares her reaction to colleagues asking her how she is. She thinks in her head, "How the hell do you think I am" (Whiston-Donaldson, 2014, p. 88). Here we get a glimpse of some of the anger, one of the stages of grief, she has bottled inside her. I had that type of anger after Jeff died too.

The story of Krista's death is told in the biography, "Left Behind: A Mother's Grief". Krista was a 15-year-old teenager who died in December of 1998 when the car that she was a passenger in hit a train in the fog. The car burst into flames on impact, the passengers died instantly and their bodies were burned beyond recognition. She had gone to spend the night with her friend, Jamie. They were going to go to a basketball game at the high school they attended.

The mother, Carol Kifer, writes the story in 1999. Her husband Darrell and their son, Jeffrey who was 11 years old at the time are a part of the story also. The chapters in the book break the process of living a life with her daughter down into sections. The sections include the funeral, Krista's room, the Holidays, Krista's birthday, and the anniversary of the death day. The chapters also offer insight into how to continue to parent the son who is still alive, how to set the table with one less plate and ask questions about when the tears might stop and where do I go to find someone who understands my grief.

The author, Ms. Kifer, shares in the book that she started to read memoirs written by other parents whose children had also died. She shared that the memoirs had a common theme

and that theme was that death is permanent and there is no changing it (Kifer, 1999). She writes “Survival involves adjustment to the absence of our special child. The adjustment comes slowly and painfully because what we are really forced to change is our inner selves (Kifer, 1999, p. 88). One of the stages of grief is denial and I believe it can be manifested in more than one way. Ms. Kifer, I believe, is experiencing a touch of denial when she talks about adjusting to the absence of her child. Our minds and bodies accept what they can (denial) until, slowly and painfully, we move to a place where we can take on the reality of our child’s death. It is permanent and there is no coming back from it. I felt similar to this when Jeffrey died. I was only able to accept so much of the pain and suffering of grief. You feel as if your mind is building a barrier to protect you (denial) until you are able to take in the enormity of the death.

Joseph was a 17-year-old teenager who died in 2002. His mother is the author of his biography titled “Grief: A Mama’s Unwanted Journey”. He was driving on a skinny, windy country road. He floated to the right and overcorrected. This caused him to swerve to the opposite side of the road. The car spun around, hit a ditch, which flipped the car on its side. The car then hit some cedar trees and the roof was crushed in. Jeffrey died instantly from head trauma.

After spending the morning running errands with his friend, Aaron, he was dropped off to pick his car up. He was following Aaron to the farm where Aaron lived with his family. The story was published in 2013, 11 years after Jeffrey’s death. Her husband, Phil and their two remaining sons, Curt and Wyatt, are part of the narrative. Jeff was the oldest with Curt being the middle son and Wyatt the youngest. The importance of family, faith in God, and participation in church ceremonies and activities are a prominent aspect of the biography. The story describes Jeffrey as a person, the parents making the decision to donate Joseph’s organs, viewing his body

after the accident, the funeral, and setting the table for one less. Ms. Ramsey discusses the difficulty of the first five years, belonging to a “club” that no other parent wants to join, and spending time and effort to stay in a healthy marriage.

Ms. Ramsey had the very same reaction I had after my son died. She writes “I was confused, however, that others went on living life when my world came to an abrupt halt. It was ugly”(Ramsey, 2013, p. 77). I can remember feeling so angry that life was going on around me as if nothing had happened when I felt the life that I wanted was taken from me the day that Jeffrey died. I can assure you, it was ugly. I think it is important to note that this particular biography was published nine years after the death of her son and she was feeling this way. This can be noted as an indication that the grieving process for a parent who does not get to say goodbye does have an influence on how much time in years a parent grieves.

Carter was a 22 year old who died in 1988. He was staying with his mother in her apartment on the 14th floor. Carter came into his mother’s room, acting erratic. She followed him into his brother, Anderson’s room, the bedroom he was using while living with his mother. The glass doors were open and Carter was sitting on the terrace wall that surrounded the balcony. He climbed over the edge of the balcony, hung suspended for a few seconds and then let go. His mother ran to the terrace wall and looked over but she couldn’t see Carter.

The mother, Gloria Vanderbilt, wrote the biography titled “A Mother’s Story” in 1997. It chronicles the childhood of her second husband, Wyatt up to his death in 1977. It also chronicles the childhood of the author, Gloria. It describes Carter from birth to his death. It tells the story of the marriage and family life of Wyatt and Gloria as they raised their two sons. Anderson Cooper is the older brother of Carter. The few days prior to Carter’s suicide are described, as is the

funeral. The book ends with Gloria's struggle to understand and comprehend the "why" of the suicide.

If there is an example of the stage of grief labeled acceptance, I think it can be found in the writing of Ms. Vanderbilt. She shares "You have the courage to let the pain you feel possess you, the courage not to deny it, and if you do this the day will come when you wake and know that you are working through it, and because you are, there is a hope, small though it may be, a hope you can trust, and the more you allow yourself to trust it, the more it will tell you that although nothing will ever be the same, and the suffering you are working through will be with you always – you will come through, and when you do you'll know who you really are, and someday there will be moments when you will be able to love again, and laugh again, and live again. I hope this will come true for you as it has for me" (Vanderbilt, 1997, p. 140-141). This biography was written nine years after Carter died. It seems this time frame is another indication that not being able to say goodbye to your child before he dies lengthens the grieving process. It appears it took her nine years to write those words.

Eric was a 25 year old who died in a mountain climbing accident in Austria in 1983. He was climbing alone this particular day. His father had to fly to Austria to claim his body. The father, Nicholas Wolterstorff, wrote the biography titled "Lament for a Son" in 1987. Claire, the wife of Nicholas and mother of Eric is mentioned as are Eric's siblings Amy, Robert, Klaas, and Christopher. Eric is described as an adult but most of the book is devoted to the journey of grief that Nicholas navigates after the death of his son. The chapters are short, many only one page. Nicholas describes the pain of grieving, how God factored in for him, the difficulty of the Holidays and how to answer questions about whether all the family would be home for

Christmas. Does he say yes even though one will be missing? He discusses how the siblings grow up around the gap that is now a part of their reality.

The book was written four years after his son, Eric, died. In reading it, I found evidence that the stage of grief labeled depression could be found in the words of Mr. Wolterstorff. One example of this is, "Rather often I am asked whether the grief remains as intense as when I wrote. The answer is, NO. The wound is no longer raw. But it has not disappeared. That is as it should be. If he was worth living, he is worth grieving over" (Wolterstorff, 1987, p. 5). Another example is "So, I own my grief. I do not try to put it behind me, to get over it, to forget it. I do not try to dis-own it" (Wolterstorff, 1987, p. 6). This mild feeling of depression is evident in my own grief journey also. I did not feel depressed, and I believe if you asked Mr. Wolterstorff he would agree with me. The depression sits near the surface of my conscious as does the grief. No, the grief is not as intense, nor is the depression, yet is there with me every day that I live here on earth without my son, Jeffrey.

There was no evidence of bargaining in any of the biographies. In four of the books, when the parents were notified, their child was already dead (Kifer, 1999; Ramsey, 2013; Whiston-Donaldson, 2014; Wolterstorff, 1987). In the fifth book, the mother was present when her son fell to his death from a bedroom terrace in her apartment (Vanderbilt, 1997). There was no time to bargain. I do remember praying to God and asking for His intervention in saving the life of my child. When the doctors from the emergency room came to Jeffrey's room to tell us the extent of his injuries and I found out that even if Jeffrey regained consciousness, though this was very unlikely, he would be paralyzed from the neck down, my prayers changed. I knew that Jeffrey would not want to live that way, unable to hold his two-year-old daughter in his arms.

My prayers then turned to asking for the strength to carry this burden of grief and the courage to live a life in a world where my son no longer existed.

Denial was not stated in two of these stories (Whiston-Donaldson, 2014; Wolterstorff, 1987). It was not a part of my own personal experience either. My sister was at the hospital with my son. She was talking to me on the phone and telling me that he was seriously injured and I needed to come as soon as possible. I didn't feel as if I had a period of denial. I could tell by what my sister and the chaplain weren't saying that it was very serious. At the time, driving in the car to Redding, California, I did not allow my mind to accept the thought that his injuries would cause his death. I wanted to see him before I let that thought come to the forefront.

In the remaining three biographies, denial came into play (Kifer, 1999; Ramsey, 2013; Vanderbilt, 1997). When Carter fell from the balcony, even though his mother saw him fall, she ran to the kitchen, told the housekeeper what had happened, and they started searching the apartment for him (Vanderbilt, 1997). When the police came to the door to inform Krista's parent that she had been killed in a car accident, her mother told the police they must have made a mistake. She wasn't wearing any identifying jewelry and the bodies were burned beyond recognition. Krista's mother told the policeman it was possible she was not in the car (Kifer, 1999). When Joseph's best friend's mother called to say that Joseph had been in a car accident, his mother headed to the hospital thinking that she was going to have to make some decision about surgery or some type of treatment for her son. She did not consider at all that he might be dead (Ramsey, 2013, p. 10).

In all five of the stories, including my own, depression was a part of the grieving process. It did manifest itself a bit differently for each of the authors. Examples will be given to illustrate these differences. “I went to work at my part-time job and then came home at 1:00 and crawled into Joseph’s bed and cried the afternoon away” (Ramsey, 2013, p. 85). Krista’s mother couldn’t sleep at all unless she took medication. She had no appetite. Food didn’t taste like anything to her and she had no energy (Kifer, 1999). Two years after Krista’s death, she was still feeling this way (Kifer, 1999). For Jack’s mother, she “made a pact with the woman in the mirror, something to tether me to a world where I do not want to be: I will not kill myself today (Whiston-Donaldson, 2014, p. 83). For me, I wanted to sleep all the time because when I was asleep I didn’t feel the hurt. I ate because I needed sustenance to live but the food had no flavor. It all tasted like sawdust. In the first weeks, I got through a day by asking myself a variation of this question over and over so that I could break the day down into manageable pieces. To get out of the bed in the morning, I asked myself:

1. What would I be doing if Jeffrey were still alive and I would answer, I would sit up in bed.
2. What would I be doing if Jeffrey were still alive and I would answer, I would put my feet on the floor next to the bed.
3. What would I be doing if Jeffrey were still alive and I would answer, I would go take a shower.

This is literally how I got through those first few weeks. I couldn’t handle the thought of a whole day without Jeffrey, so I broke the day down into seconds and minutes. I felt like it was the only way I could survive psychologically.

Ms. Vanderbilt did not express anger in any form when Carter died by suicide. She did not understand why he made the decision that day but she was not angry. Mr. Wolterstorff did not talk about anger in his book either when his son Eric died in a mountain climbing accident. He did ask himself the question “Why did he do it?” (Wolterstorff, 1987, p. 20). This question was in reference to why Eric decided to mountain climb alone that day. In the other three stories, the anger manifested in different ways. For Jack’s mom, who drowned in a creek turned into a river by heavy rains caused by a nearby hurricane, the anger was directed toward God. She didn’t understand where the miracles were or the angels the Bible talks about. She asked herself how she could continue to trust a God who thought it was a good plan to take her 12-year-old son from her (Whiston-Donaldson, 2014). Joseph’s mother was very angry with the doctor who came out to the waiting room and told her that her son was dead (Ramsey, 2013, p. 12). Krista’s mom was angry at an object, the train itself (Kifer, 1999, p. 53). The family packed up all their model trains because she could not bear to look at them. For me, I don’t remember feeling angry with anyone or anything in particular but I did carry a deep anger at the world in general. In my mind, I wanted to know how the people could smile, laugh, and have fun when my son was dead. When I returned to work as the office manager of an elementary school, I was quick to snap at people I judged were asking silly questions. Looking back, I returned to work too soon. I wasn’t ready emotionally to deal with parents, students, and staff. I do remember that the faith I had before my son died changed forever at his death. I no longer believe in an all-powerful God. If that were the case, He would have saved my son. I now believe in an all-loving God. Jeffrey did not die alone. God was with him.

Each of the five parents came to a place where their grief had eased but none of them used the word acceptance to describe their feelings. Ms. Vanderbilt said about the suicide of her

son, Carter that she believed that the day would arrive when her question about why he died would be answered. She said, "It takes a great leap of faith to believe this, but I do, and in some measure it has brought me peace" (Vanderbilt, 1997, p. 139). Eleven years after the death of her son, Joseph, Ms. Ramsey states "I have opened a window and made a place for God to mature me. He is using the death of my son to refine my faith (p. 113). Ms. Kifer wrote at the conclusion of the biography about her daughter, Krista, that "Life is good. It's not everything I hope or planned, but it still has its moments. I am at peace with myself, with God, with reality" (p. 157).

Acceptance is not a word I would associate with the death of a child. I do not use that word when speaking of Jeffrey's death. I can say that after ten years, my grief is more manageable. I am used to what grief feels like on my skin and I don't feel it the same way that I did when Jeffrey's first died. The grief is with me every second of every day but its touch is softer now. It still only hurts when I breathe but most days now, I can breathe. In the days after Jeffrey's death, every breath felt like agony, knowing that each inhale and exhale took me farther and farther away from Jeffrey as my living son. I can say today that I still no longer have the life that I want because Jeffrey is not in it but I do have a life that I can live with until the day I am reunited with my son in heaven. On that day, I will know peace.

Discussion

The biographies and the articles read for this current study support the research question as stated. The type of death, specifically traumatic death in which the child dies by homicide, by a drunk or drug impaired driver, or accidental death, does have an effect of the number of years a

parent will grieve. The number of years differed from three years to nine years but the consensus was still clear. Traumatic death of a child adds to the years a parent grieves.

In each of the stories outlined above, there are three common threads weaving through the narratives, first is that each of the five deaths were by a traumatic event and the parent was not able to say goodbye. This common thread is also woven into my own personal grief journey. Secondly, each parent, including myself, struggled to be a parent to his or her remaining children while trying to navigate the grief each was feeling, and thirdly, each parent described the deep, abiding, and painful sorrow they were dealing with in every waking moment of their lives after the death of their child. I walked that path also with the death of my son, Jeff.

A deliberate action took place to choose five different modes of traumatic death in the research for this study. I wanted to see if a similar grieving process would take place for each type of traumatic death as it related to length of bereavement or if the length of bereavement would only apply to one type of traumatic death. Effort was also made to find biographies written by both mothers and fathers whose child had died. Research in that area found little instances in which the father had authored a book. Many of the stories, including the ones not used for this study were written by the mother.

Studies indicate that the grieving process is elongated in years when a child dies a traumatic death. Two of the studies specified an amount of years (Tombrink Dierkhising, 1992; Kindrachuk, 1994). Between the two studies there was a range of three to nine years. In the thesis written by Sheryl M. Kindrachuk for her master's in school psychology, she states that the time frame can be as long as seven to nine years. This statement holds true with my personal experience as to the traumatic death of my son, Jeffrey. For me, the grieving process continued up to eight and one half years. We continue to study this concept as we outline the biographies.

The biographies and the articles also supported the work of Dr. Elizabeth Kubler-Ross (1969) and the five stages of grief. Each of the five parents who shared the stories of their child's death spoke of denial, and depression they felt in the months and years after. Anger of some type was present in three of the five the biographies but notice should be given that when the death of the child was due to the negligence of another person, the anger took on an element of rage and revenge against this negligent person. The bargaining stage, for the most part, is absent in a situation where a traumatic death has occurred because the child was dead when the parents were notified. There was no time to bargain and the parents shared this in their writings. Acceptance, as a stage, was not expressed by any of the five parents. It may be acceptance is the wrong word to describe this stage. A better descriptor could be management of the grief. A common theme in the five biographies and in the research articles was one that is not mentioned as a stage. This theme is guilt. All five parents expressed guilt, though it took on different forms. For Krista's mom, she berated herself for allowing Krista to go to the basketball game at all (Kifer, 1999). Jack's mother was upset with herself for allowing Jack to go out and play in the rain (Whiston-Donaldson, 2014), and she worried that her husband would not be able to forgive her for the decision she made that day. Carter's mother wondered what would have happened if she had realized something was troubling her son (Vanderbilt, 1997). For me, I wondered if there was something I didn't say or didn't impart to Jeffrey that would have caused him to make the decision to not hook the harness to the line to keep him safe. For some parents, the guilt was a fleeting thought and when the reality of having no control over the death of their child became evident to them, the guilt dissipated.

Logically, it makes sense that not being able to say goodbye to your child would add a deeper layer of grief. Anticipatory grief, which comes about when a child dies from an illness, is

not present in traumatic death (Kubler-Ross, 1969). In this case, a parent can begin the grieving process before their child dies. They know it is going to happen and they began to prepare themselves, if that is even possible, for what is to come. This cannot be done with a traumatic death. There are no final words, kisses, or resolutions of outstanding issues. Your child is dead. This can have important implications for treatment therapies for these parents. Careful attention must be paid to their particular experiences.

In the real world, suggestions for therapy could be three fold, theoretical, empirical, and practical. First, from a theoretical standpoint, there is a strong indication that the five stages of grief come into play no matter the mode of death of the child. With traumatic death, the circumstances are unique to the death of the child and what applies to a grieving parent in general would warrant modification for this sub set of parents. In reading the five biographies and in my own story as well, there was consensus that bargaining and acceptance do not apply to the sub set of parents whose child has died in a traumatic fashion. As there is no time to bargain because the child is already dead when the parents are notified, I believe this stage should be removed.

Acceptance is not a word that was used by any of the five authors, including myself. I believe the stage labeled acceptance should be renamed as management of grief. The authors whose child died in a traumatic fashion expressed no acceptance but they did share how they learned to manage their grief in the midst of the daily life that continued after the death of their child.

Based on the biographies, I believe it is time to explore adding a new stage labeled guilt. Four of the five authors wrote about some level of guilt they felt after the death of their child. This was my experience also. The time has come to modify the stages to better address the

specific grieving process of parents whose child has died by a traumatic death. These five updated stages would be denial, anger, guilt, depression, and management of grief. If we are to adequately provide therapy for these parents, we must use information that fits the grief that is particular to the circumstances of the death of their child.

Empirically, research on the specific topic of traumatic death and the impact on the grieving parent have been limited. An opinion of the results of the findings must be put on hold until more research is done. It is important to state here that research of this type is vital to creating a therapeutic framework that could be used in counseling parents who have experienced the traumatic death of a child. The type of death itself adds a dimension that must be addressed if proper care and concern is going to be given to these parents when or if they seek therapy.

From a practical perspective, based on my own personal experience with the death of my son, Jeffrey, I offer five suggestions to help in the grief work to be done with parents who child has died a traumatic death or as a “heads up” to well meaning friends and family:

(1). Please do not offer in platitudes or clichéd remarks such as “It is God’s will” or “God took your son home because he was protecting you from something terrible that he was going to do” (actually said to me). From my own perspective, these remarks only served to anger me. Keep it simple and just say you are sorry.

(2). Please do not ask the grief stricken parent what you can do for them. They don’t know. They are hurting too bad to form coherent thoughts. I used to ask people if they could bring Jeffrey back. When they said no, I said, then there is nothing you can do for me. Pick something and do it. When Jeffrey died, I had a friend who would show up at my door with a coffee or call me and ask me what I wanted from “Burger King.” She

would then show up at my front door, knock, hand me the bag, give me a hug, and go home. Her kindness and thoughtfulness meant everything to me.

(3). Do not under any circumstances tell the parent whose child has just died that you understand what they are feeling. Unless a person has lived beyond the death of their child, there is no way they know what you are feeling. This type of grief is different from all others. A parent is not supposed to outlive their children. Grieving becomes “a life-long process of adaptation to such an unexpected, unnatural occurrence “(Kindrachuk, 1994, p. 75).

(4). Please don’t judge us. Please don’t tell us there are things we shouldn’t be doing unless they are harmful to our bodies or our psyche. If the grief stricken parent feels some comfort in having her son’s ashes in a small, decorative urn on her nightstand, who are you to tell her she is being morbid (actually said to me)? I said when your son dies, you come back and tell me what I should and shouldn’t do. Until then, the choice is mine.

(5). Please allow us to grieve in our own time. This is our journey in grief, not yours. There is no date in the future when we must finish this task. It takes the time that it takes. Do not say, “You are not crying, you must not be very sad” (actually said to me). Listen, offer to listen, and listen some more. Do not change the subject when they want to talk. The grieving parent wants to tell stories and share memories. Let them. It is one of the sweetest gifts you can give them. My sister-in-law told me after Jeffrey died that I was soon to discover who my true friends were. I didn’t understand what she meant at the time that she said it. I later came to discover that she was more right than I could I have ever imagined.

Future research in the area would be interesting along four different avenues. The first would be as to whether there are differences in the way mothers and fathers grieve the traumatic death of a child. Fathers were interviewed (Carter, 1997; Kindrachuk, 1994; Quayle, 1999), but differences in gender were not addressed. During the gathering stage of information for the purpose of this study, the mother was almost solely the author of the biographies I investigated. In the research articles also, women were the major contributors to the scientific gathering of information about the traumatic death of their child. Research does indicate that men and women grieve differently (Carter, 1997; Quayle, 1999), but do these same differences manifest themselves when the child dies a traumatic death? It is a valid question from a therapeutic standpoint and warrants investigation.

Secondly, a research study specifically focused on years since a traumatic death of a child occurred could be investigated. Parents could be interviewed and/or surveyed whose children had died from eight to fifteen years previous. A comparison could then be made to current literature to determine if the grieving is still being experienced. This knowledge could add useful information to be used in therapy with parents whose child has died from a traumatic death.

Thirdly, researchers could look at a traumatic death and the age of the child. Are there differences that manifest themselves when a child is still living at home as compared to a child of adult age who has moved out? When there is less contact with the child and there is no disruption to the flow of the household, is the grief for the adult child different? When a child is no longer living at home, there are no bedrooms to pack up or decisions to be made about what to save and what to donate. Are there differences in grief levels when a child is four years or younger as compared to a child who is elementary school age? Does how much the parent cares

for the child's needs add to the level of grief experienced after the death? These are valid questions in the study of traumatic death of a child and parental grief.

Lastly, and this may be the most important area for future research, I believe it is time to look at Kubler-Ross's original work and update it to fit grief in particular. The five stages she writes about were originally meant to aid those who were dying from a terminal disease. If we are to provide adequate therapy for parents whose child has died by a traumatic death, we must begin to tailor the stages to fit grief. The five original stages were denial, anger, bargaining, depression, and acceptance. Based on the five biographies read and discussed for the purpose of this paper, research should begin to change the five stages to denial, anger, guilt, depression, and management.

In all five of the biographies bargaining and acceptance were not present. Bargaining does not apply in the case of traumatic death because the child is already dead when the parent is notified. There is no time to bargain and there is no time to say goodbye. Acceptance is not a word used by any of the five parent authors either. The parents spoke of a coming to a place of peace (Kifer, 1999; Vanderbilt, 1997), and a strengthening of faith (Ramsey, 2013). The word acceptance was never mentioned. This is true in my own personal story also. I have learned to manage my grief as the years have gone by. It is not easier but the grief weighs less heavily on me than it did when he first died. It is time to remove bargaining and acceptance and replace them with management (of grief) and a new category, guilt.

Guilt was expressed in some form by all five parents in their biographies. For some it was fleeting and dissipated when they realized they had no control of the death of their child (Ramsey, 2013; Wolterstorff, 1987). For the other three, it was evident in their writings (Kifer, 1999; Whiston-Donaldson, 2014; Vanderbilt, 1997). Ms. Kifer felt that Krista's death could

have been avoided if she had made her stay home that night. Ms. Whiston-Donaldson felt that Jack would still be alive if she had said no when he asked to go out and play in the rain. Ms. Vanderbilt berated herself because she did not acknowledge the signs that something was not right with her son, Carter. Guilt is very definitely an emotion that is present when a child has died by a traumatic death.

To reiterate what has been stated above, in order to adequately provide therapy that will be helpful in dealing with parents whose child has died a traumatic death, we must tailor that therapy to match their particular set of needs. One step toward doing just that is to examine the five stages of grief as they are currently presented and if warranted, update them to more precisely fit the grief patterns of this particular set of parents. The five stages, after careful research, could be denial, anger, guilt, depression, and management.

The suggestions above for future research are only a few of the limitless possibilities available. Systematic research into grief, loss, sudden loss, and the death of a child is not abundant (Quayle, 1999). It is an area that warrants further study. Some parents whose child has died a traumatic death need therapeutic intervention in order to survive the emotional devastation caused by such an event. We need to conduct the proper research to have the guidelines to help and not harm them further when and if they ask for that support. These parents deserve the attention of a compassionate and well-informed therapist. All parents should have the opportunity to work with a therapist who understands the specific needs that come into play when the child dies a traumatic death. Further research in the area could begin to make that therapeutic opportunity available.

I received that kind of support from my therapist and I am living testimony that having

her listen to me had a very definite impact on my grieving process. It did not shorten it but it did ease it just a bit. My heart will always be grateful to her for that.

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